# SCHEDULE 2 – THE SERVICES

## A. Service Specifications

*This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.*

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| **Service Specification No.** |  |
| **Service** | Hospital Discharge Scheme for Single Homeless Adults |
| **Commissioner Lead** | Olga Buck |
| **Provider Lead** |  |
| **Period** | 3 Years |
| **Date of Review** | 1st May 2025 |

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| **1. Population Needs** | | |
| **1.1 National/local context and evidence base**  It is nationally noted that homeless people tend to have poorer health outcomes when compared to the rest of the population. On average homeless people die by the age of 30 which is significantly below the national average. Rough sleeping can contribute to ill health both physically and mentally and can also lead to drug and alcohol abuse.  Homeless people are at the risk of exploitation and exclusion due to life factors such as poverty and illiteracy and often seek medical treatment at a later stage during illness, leading to costly secondary health care and worsened health outcomes. Exacerbated by this is the reduced potential for recovery due to many homeless people returning to insecure accommodation or even rough sleeping after medical treatment. In some cases, accommodation may be lost during hospitalisation, resulting in a decline in a patient’s housing situation on discharge and in other cases there may be issues with their refugee status, right to remain ordinary residency. Tenancy sustainment is therefore challenging and unpredictable so this cohort of people tend to stay in hospital a lot longer, making inappropriate use of medical facilities and occupying beds that should be made available for sicker people.  In the year 2016/17 approximately 67 patients were categorized as delayed transfers accounting for 674 bed days at the Royal London Hospital. This delayed discharge cost approximately £420,000 per annum. NHS North East London are seeking to provide a hospital discharge hostel to expedite discharge for medically optimized patients that are homeless. Working collaboratively with housing and other support professionals the service will offer short-term support that focuses on support to promote recovery from illness, prevent further acute hospital admissions, support timely hospital discharge and maximise independent living for those who are homeless or rough sleeping. The recovery and support provided post-discharge will aim to help people return to the quality of life they had prior to their most recent admission. For some people this may require support for additional needs for the optimum period of up to six weeks, although for the majority it will be suitable for them to move on in less time. The service will to work closely with Adult Social Care, Housing, Rough Sleeping, relevant Health services including primary care and the voluntary sector.  Monitor and manage supported housing tenancies addressing risks such as arrears, absence, difficult behaviour, access and changes in mental capacity. | | |
| **2. Outcomes** | | |
| **2.1 NHS Outcomes Framework Domains & Indicators**     |  |  |  | | --- | --- | --- | | Domain 1 | Preventing people from dying prematurely |  | | Domain 2 | Enhancing quality of life for people with long-term conditions |  | | Domain 3 | Helping people to recover from episodes of ill-health or following injury | x | | Domain 4 | Ensuring people have a positive experience of care | x | | Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm |  |   **2.2 Local defined outcomes**   * Reduced DTOC days at RLH * Positive patient experience of hostel residence * Guests access appropriate accommodation * Guests access appropriate community services * Guests manage their health * Guest avoid unplanned hospital treatment * Guests access appropriate health services * The scheme will reduce the delayed transfer for those with a housing or immigration need, which in turn will reduce the length of stay for these patients. * The scheme will also support people into stable accommodation, reducing the numbers of people experiencing homelessness or unstable accommodation.   **2.3 Local defined outcomes**   |  |  | | --- | --- | | Specific aims | * Outcomes | | Provide safe, comfortable accommodation for vulnerable adults | * Reduced DTOC days at RLH * Positive patient experience of aftercare | | Support guests to move to appropriate accommodation | * Guests access appropriate accommodation * Guests access appropriate community services | | Support guests to manage their health | * Guests manage their health * Guest avoid unplanned hospital treatment * Guests access appropriate health services | | | |
|  | **Objectives Outputs** | | |  |
| **Provide good quality manageable accommodation that affords dignity, privacy and comfort.** | * Letting data * Guest satisfaction surveys | |
| **Develop an integrated partnership model with RLH and Pathways and**  **providence row** | * Service specification * Joint working protocols * Operational procedures * Performance metrics * Evaluation report * Steering group | |
| S**upport eligible patients to be discharged by RLH** | * Discharge plans * Risk assessments * license agreements * GP registrations * Personal care packages | |
| **To support guests to manage and maintain their health** | * Support plans * Nutritional meals * Medication compliance * Completed healthcare appointments * Income maximisation | |
| * **Support guests to return to their country of origin or to reconnect with their local area** * **Support guests to remain compliant with home office legal conditions** * **Support guests to find alternative accommodation** * **Maximise appropriate welfare benefit income for guests** | * Section 4 activities * Asylum support activities * Homelessness application activities * Hostel key working sessions * Translation services | |
|  | * **Protect guests, the public and employees from harm** * **Safeguard vulnerable adults** | * Support plans & Risk assessments * SOVA referrals * SOVA case conferences * Personal safety training * Accident and incident reporting | |  |

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| **3. Scope** |
| **3.1 Aims and objectives of service**     * Specific Aims - To provide temporary accommodation to vulnerable adults medically fit for discharge from the Royal London Hospital (RLH). Specific aims: • Provide safe, comfortable temporary accommodation * Support guests to move on to appropriate accommodation * Support guests to manage their health Objectives: * Provide good quality manageable accommodation that affords dignity, privacy and comfort. * Develop an integrated partnership model with RLH and Pathways and providence row * Support eligible patients to be discharged by RLH * Support guests at the hospice to access appropriate primary care and personal care services * To support guests to manage and maintain their health * Support guests to return to their country of origin or to reconnect with their local area * Support guests to remain compliant with home office legal conditions * Support guests to find alternative accommodation * Maximise appropriate welfare benefit income for guests * Protect guests, the public and employees from harm * Safeguard vulnerable adults * The scheme will reduce the delayed transfer for those with a housing or immigration need, which in turn will reduce the length of stay for these patients. * The scheme will also support people into stable accommodation, reducing the numbers of people experiencing homelessness or unstable accommodation     **3.2 Service description/care pathway**   * The service will provide a six bed accommodation offering short-term support for vulnerable adults who medically fit to be discharged from hospital, but who are unable to be discharged because of a housing need. The service will support those who are homeless or rough sleeping to access suitable housing and welfare services in the community whilst helping them to recover from illness, preventing further acute hospital admissions, and maximise independent living. The aim is to ensure people return to the quality of life they had prior to their most recent admission. This may take up to up to six weeks, although it is hoped that most of them will move on in less time. . The service will to work closely with Adult Social Care, Housing, Rough Sleeping, relevant Health services including primary care and the voluntary sector. Referrals will be made by the Pathways team in the hospitals based in the London Boroughs of Tower Hamlets, Newham and Waltham Forest.      1. **Property profile**  * A 6 room shared house in the London Borough of Hackney or Tower Hamlets with a shared communal lounge, kitchen, laundry room, and at least 3 bathrooms. Ideally the premises should have wheel chair accessibility and the building should conform to all the requisite fire safety regulations.  1. **Tenure**  * Guests will be required to sign license agreements and to abide by the house rules. This type of tenure grants the landlord greater control over tenants and to take possession without court application, in the event of serious tenancy breaches. * Housing associations are not legally required to witness personal identification before offering a tenancy, however ID will be mandatory for all other landlords to enter into a tenancy agreement and for the purpose of making a welfare benefits or housing benefit application.  1. **Provisions**  * Each guest should be provided with a simple starter pack that includes bed linen, a duvet set and some essential sanitary products. This will become the guest’s possession once they move on from the service. * The shared kitchen should be fully equipped with an oven, microwave, cooking utensil and crockery. The property should have a communal washing machine and tumble dryer, for laundering linen and clothing and there should be a fully furnished shared lounge equipped with communal television * Guest should be prompted and assisted to take medication with supervision if necessary. Guests that require greater assistance will have medication records maintained by the staff team.  1. **Operating hours**     * The hostel should operate 24 hrs a day, 7 days a week. It should be staffed 08:00 - 21:00 with a security concierge present 21:00 - 08:00.    * Community Support & Appointments – Staff will be expected to undertake a limited number of escorted appointments each week, however the service will not generally offer community outreach to guests.    * New guests will be received 7 days a week 09:00 - 19:00 if appropriate referral documentation has been completed by pathways and formerly accepted by hostel staff. 2. **Staffing**   The staff team consist of:   * **Team leader (0.4 x FTE)** - responsible for staff supervision, stakeholder liaison and Health & safety. * **Resettlement officers (3 x FTE)** - responsible for supporting guests to arrive and settle in, manage their tenure, access suitable welfare benefits, remain safe, maintain their health, and move on to their local area, country of origin or future accommodation. * **Security concierge** - will maintain a security presence overnight to manage access to the building and prevent antisocial behaviour or criminal activity.   **3.3 Population Covered**     * Homeless vulnerable adults medically fit for discharge from hospitals in the London Borough of Tower Hamlets, Newham and Waltham Forest.   **3.5 Client profile and eligibility**  Patients being referred to the hostel must meet the following eligibility criteria:   * Have a discharge plan * Are medically optimised and able to mobilise independently * Have appropriate arrangements in place for personal or nursing care * Have appropriate arrangements in place for the dispensing and or administration of prescribed and controlled drugs * Have mental capacity to understand the tenancy agreement * Are able to self-medicate with some supervision and prompting * Do not present a serious risk to others * Either have the right to reside in the UK, asylum seeking status or section 4 asylum support agreed by the customs and boarders agency     **3.6 Interdependence with other services/providers**   * Referrals can only be made by the Pathways team.   Discharge planning and aftercare arrangements including dispensing of medication will be undertaken by the Royal London Hospital, Newham University Hospital or Whipps Cross Hospital. |
| **4. Applicable Service Standards** |
| **4.1 Asylum support policy and process**  **NRPF factsheet**  **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**    **4.3 Applicable local standards** |
| **5. Applicable quality requirements and CQUIN goals** |
| **5.1 Applicable Quality Requirements (See Schedule 4A-C)**  **5.2 Applicable CQUIN goals (See Schedule 4D)** |
| **6. Location of Provider Premises** |
| The Hostel should be based in the vicinity of the London Borough of Tower Hamlets and Hackney |
| **7. Individual Service User Placement** |
| Not Applicable |